



PERSONAL HYGIENE CHECKLIST

Year: _____ **Month:** _____

Week date from: _____ **to** _____

Name of Staff	Protective clothing worn Yes/No	Clothing clean & good state Yes/No	Head covering worn Yes/No	Protective shoes worn Yes/No	Finger nails short & clean Yes/No	NO jewellery worn Yes/No	NO uncovered skin wounds Yes/No	Staff in good health Yes/No	NO bad body odour Yes/No	NO strong perfumes aftershaves Yes/No	If you answered NO to any checkpoint, please comment on what was done to rectify	Signature: Please sign that you have checked